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Hospitals For California

PART I

THE HOSPITAL SURVEY AND CONSTRUCTION PROGRAM—1946-1952

Origin of Program

The American Hospital Association in 1941 sponsored creation of an independent Commission on Hospital Care in the United States. This commission began its work in 1944 and published its report in 1947. Californians on the commission were Herbert Hoover, the Right Reverend Monsignor Thomas O'Dwyer, and Wilton L. Halverson, M.D. The purpose of this commission was to make an independent objective analysis of hospital problems in the United States. One of the conclusions and recommendations of the commission's report relating to hospital construction was that in instances where sufficient local funds cannot be raised, public funds should assist the construction of hospitals.

This is a condensation of the progress report of the same title that has just been published by the California State Department of Public Health. The full 36-page report contains numerous tables, maps and charts giving detailed statistical information from 1946 through 1952. Copies have been sent to local health officers and to administrators of most of the hospitals in the State.

Federal and State Laws

Public Law 725 of the Seventy-Ninth Congress (Hill-Burton Act), effective August 13, 1946, established a basis for allocation of federal funds to assist local communities in building hospitals and health facilities. California, by enactment of Chapter 327, Statutes of 1947, established the legal basis for California's participation in this national program.

These federal and state laws make it possible for communities to secure financial assistance in constructing general hospitals, tuberculosis hospitals, chronic disease hospitals, mental hospitals, and public health centers. Federal funds are allocated to states each year, the states being responsible for distribution of funds to individual projects. To insure that distribution of funds will be on an objective basis, each state is required to engage in continuous research and investigation of hospital needs within the state. Based on this information, a state plan is developed each year which evaluates relative need for additional hospital facilities in the various areas of the state. The plan also contains priority lists for consideration in the allocation of the limited funds available for distribution.

Brief Description of Program

The program's purpose is to assist local communities in obtaining better hospital care through the orderly expansion of present hospital facilities in each state.

Assistance consists of grants which are not repaid. When a project is completed, the local community organization which sponsors the project has clear title to the facility and is not subject to federal control or direction, nor to any state control or direction except general provisions of the state law which relates to all hospitals in the state. Assistance under the program is limited to aid in constructing and equipping the facility. No assistance is available for operation of the institutions. The objective is that hospitals and health facilities which are assisted will operate in exactly the same manner as any other community hospital or health facility in the state.

Hospitals which are operated for profit are ineligible for consideration in this assistance program. Hospitals

and health facilities sponsored by nonprofit corporations and by units of government such as counties, districts, and cities, may qualify for federal funds not to exceed one-third of the cost of building and equipping the facility. Projects sponsored by counties, hospital districts, and cities also qualify for state funds in an amount equal to the federal aid. Projects sponsored by nonprofit corporations have not qualified for state funds until approval of Proposition 20 in the November, 1952, general election made it possible for the Legislature to make state funds available to nonprofit hospitals on the same basis as federal funds.

Policy in Allocating Funds

California law provides that in administering this program the State Department of Public Health will act with the advice of an Advisory Hospital Council, members of which are appointed by the Governor and serve without compensation. The department has, without exception, followed the recommendations of this council in administering the program.

The program is operated under the following policy:

Public funds shall be allocated in amounts that will insure the building of adequate and satisfactory facilities, but only to the extent necessary to insure that proper and adequate hospital and health services will be made available.

The Advisory Council and the department recognize a responsibility to obtain for the people of California maximum service for dollars invested in hospitals and health facilities which are partially financed from funds available for this program.

Applications for grant of public funds will be reviewed and considered by the council and the department, and allocation of funds will be recommended and approved only for projects proposing to construct and equip facilities which demonstrate community needs and resources to support a reasonable expectancy of effective use and which present a building program for a physical plant of minimum space, finishes and equipment representing a reasonable investment for the community.

ADMINISTRATION OF PROGRAM

Basis of Establishing Need for Hospital and Health Facilities

For purposes of general planning on a state-wide basis, following are the needs of the State in each category of health and hospital facilities as estimated by the State Department of Public Health:

General hospitals	4.5 beds per 1,000 population
Mental hospitals	5 beds per 1,000 population
Chronic hospitals	2 beds per 1,000 population
Tuberculosis hospitals	2.5 beds per annual tuberculosis deaths
Public health centers	Space necessary to accommodate functions of organized health departments

Regional Distribution

In estimating the need for all communities and areas of the State, it is recognized that larger cities supply some of the more specialized hospital, medical and related health services for rural areas.

In recognition of this relationship between communities, the State is divided into 14 regions for the purpose of planning and establishing the distribution of general hospitals, tuberculosis hospitals, chronic disease hospitals, and mental hospitals. These hospital service regions may be described as a grouping of hospital communities which have, or may establish, cooperative inter-relationships on a voluntary basis to provide adequate and complete hospital and health services. The development of working relationships between small hospitals and larger medical centers includes advantages for each group. Such arrangements can readily be developed for professional services, diagnostic and therapeutic facilities, administrative cooperation, and education opportunities.

The boundaries of the 14 regions recognize natural geographic barriers, routes of transportation, trade centers, and similarity of interests. The designated regional center contains the largest hospitals, ordinarily the most complete facilities and the most specialized medical personnel. It is the intent here to emphasize the importance of considering the regionalization concept in hospital planning, and not to imply that each of the 14 regions now has facilities to provide complete services.

General Hospitals

These are institutions which provide short-term acute care, primarily for medical, surgical, and obstetrical patients. Basing need of the entire State on 4.5 beds per 1,000 population, it is recognized that larger cities supply specialized hospital service for more rural areas, and accordingly have need for a greater ratio of beds per 1,000 population. In analyzing the needs for general hospital beds the 14 hospital regions are divided into 110 hospital service areas, in compliance with the following principles:

1. In isolated rural sections of low population to provide service within one-hour travel time of area residents an area is established where population to be served exceeds 5,000; where population is less than 5,000 it is not feasible economically, to support a hospital.
2. In sections of greater population, areas are created to provide facilities within 30 minutes travel time of all area residents. The principle of service within 30 minutes applies to areas which can support 50 or more beds.
3. In metropolitan regions with relatively high density of population and congested transportation

facilities, areas are created to reflect major community groupings for hospital services, including medical and related activities. Recognizing the inter-relationships of population and its fluidity for purposes of employment, business, medical, hospital and other activities, areas are established which combine communities within reasonable distance and travel time of the established centers within the region.

An index of need is established for each area, expressed in number of beds per 1,000 population. This varies from 2.5 beds per 1,000 population in rural areas to more than 6 beds per 1,000 in metropolitan teaching centers.

Though the State as a whole has only approximately two-thirds of the state-wide need of 4.5 beds per 1,000 population, some of the 110 hospital areas have all the beds considered necessary, while other areas are critically short of needed facilities.

In determining sequence for assisting general hospital projects, a priority list is developed each year in which each of the 110 areas is included on the basis of relative need. This need determination is based on the percentage of need met in the area.

Most of the 58 counties of California have county hospitals which provide county-wide service. In some instances hospital service area boundaries and county boundaries coincide, whereas in other instances one county may be divided into two or more hospital service areas. When county and service area boundaries are not identical, beds in the county hospital are prorated to the various hospital service areas in the county for purposes of determining in the state plan the number of beds available to serve each hospital service area.

Mental Hospitals

The state plan establishes need for five mental beds per 1,000 population in the State. State mental hospitals provide most of this service. However, hospital and health authorities recognize the need for short-term mental care in general hospitals or in institutions closely affiliated with general hospitals. The plan seeks to encourage development of this type of short-term service. At present very few facilities of this type exist, and it is impractical to develop a detailed priority list for short-term mental facilities.

Chronic Hospitals

The state plan establishes need for chronic facilities in the ratio of 2 beds per 1,000 population. Chronic facilities, as defined in this plan, are hospitals the primary purpose of which is to provide specific medical and other treatment for chronic patients. A chronic facility is not a custodial institution, but one in which skilled staff and facilities will be made available to permit specialized care directed toward physical rehabilitation and recovery of patients so that they may return to their homes and, at least in some cases, to their occupations. The state plan contemplates assistance in this category to chronic units which are departments of general hospitals or to institutions closely affiliated with general hospitals. Bed needs of the State are computed for each of the 14 regions of the State, and projects receive consideration on the basis of their service programs, including community resources for rehabilitation rather than under a detailed priority plan. At present county hospital plants operate the majority of these chronic disease hospital beds.

Tuberculosis Hospitals

Most tuberculosis institutions in California are county hospitals. In computing the need of tuberculosis beds this is recognized; and the 28 areas established in the state plan are individual counties, or groups of counties when it appears logical that two or more counties should combine to support one facility. Application for tuberculosis projects are considered in priority sequence.

Health Centers

Health centers are physical plants in which to conduct the organized activities of county, city, and district public health departments. The space estimated to permit service in jurisdictions of various population sizes has been determined with the valued assistance of the California Conference of Local Health Officers. For consideration under the program, jurisdictions are listed in priority sequence based on percent of need met by existing acceptable square-foot building area with some preference for jurisdictions of small population.

Conditions Required of Projects Which Receive Assistance

Nonprofit corporations, counties, cities and hospital districts make application by completing a form which describes the proposed building program, estimates its cost, and indicates the source of local funds to finance the project. Applicants agree to the following conditions in the event allocations are made to them:

1. The hospital will be operated in nonprofit status for a minimum of 20 years. (If nonprofit status of institution ceases within this period, the Federal Government reserves the right to secure reimbursement.)
2. The hospital agrees to accept patients without regard to race, creed, or color.
3. The hospital agrees to provide a reasonable amount of free care, unless other arrangements exist for providing this care. In California, which has a system of county hospitals, this provision means that the hospital accepting assistance under the program agrees to provide care for

emergency cases until they can be transferred to a county hospital.

4. The hospital agrees to certain technical matters relating to construction of the facility, including competitive bidding, payment of prevailing wages, and approval of plans and specifications by the State and Federal Governments.
5. Compliance with standards of the California licensure program administered by the State Department of Public Health is required. This licensure program requires construction and operation of licensed hospitals throughout the State in compliance with minimum standards established by state law. These construction standards are substantially the same as those established by the Federal Government for projects which are assisted under the hospital survey and construction program.

Each year when federal and state funds are available for distribution to projects, applicants are given the opportunity to present information in support of their applications to the Advisory Hospital Council. Following consideration of presentations by applicants and consideration of factual data developed by the staff, the Advisory Council recommends allocation to projects in accordance with priority which has been established on the basis of relative need in the various areas of the State. The department, acting on the recommendation of this council, allocates funds to projects with the condition that necessary local funds to finance the project will be available within four months. Should a community fail to secure local funds within four months, the allocation is withdrawn and the funds are allocated to another project.

Construction and Reimbursement

The general policy under this program is that construction shall follow the usual processes of private commercial industry, and that the owner shall assume the primary responsibility for planning, constructing and equipping of the facility.

Funds are disbursed on a reimbursement basis, which means the owners must pay bills as expenses occur and periodically be reimbursed for these expenditures by the state and federal agencies. The state agency conducts periodic inspections to verify compliance with plans and specifications, and certifies reimbursement. Inspections are normally made at each 20 percent increment of construction.

An audit and inventory is conducted when construction is substantially complete and a majority of the equipment is in place. No payment beyond 94 percent of total participable costs is certified until a federal audit has been completed.

(Part II will appear in the next issue)

Sanitation Manual for Disaster Use to Be Basis for Training

The Division of Medical and Health Services, which is part of both the State Office of Civil Defense and State Department of Public Health, has recently published a "Sanitation Manual for Disaster Use." This 55-page manual, a product of the combined efforts of over 80 experts in public health and allied fields, is a series of operational guides pertaining to water, sewage, food, housing, vector control, and refuse disposal.

A training plan has been developed which utilizes the sanitation manual as a basic aid for training representatives of state and local health departments in sanitation procedures during time of disaster. It is suggested that local health department personnel after attending the course will extend this training to other members of their own departments and also to representatives of other agencies, such as utilities, engineering, and mosquito abatement districts, which normally operate in fields covered by the manual.

The purpose of this training course is to facilitate strengthening of the lines of communication and coordination among all agencies involved in a common disaster problem, before any such disaster strikes, and to make them aware of the safe way of performing the operation and of each other's responsibilities.

Both the training plan and the manual have been approved by the California Conference of Local Health Officers.

It is expected that the first class will be presented at the Fresno Vector Control Field Station of the State Department of Public Health; times and dates to be announced later.

Health Officer Changes

Full-time Jurisdictions

Dr. Saul Ruby resigned May 1st as health officer of Placer County to enter private practice in Auburn. Dr. Ruby will continue his connection with the health department on a part-time basis as acting health officer until a full-time successor can be obtained.

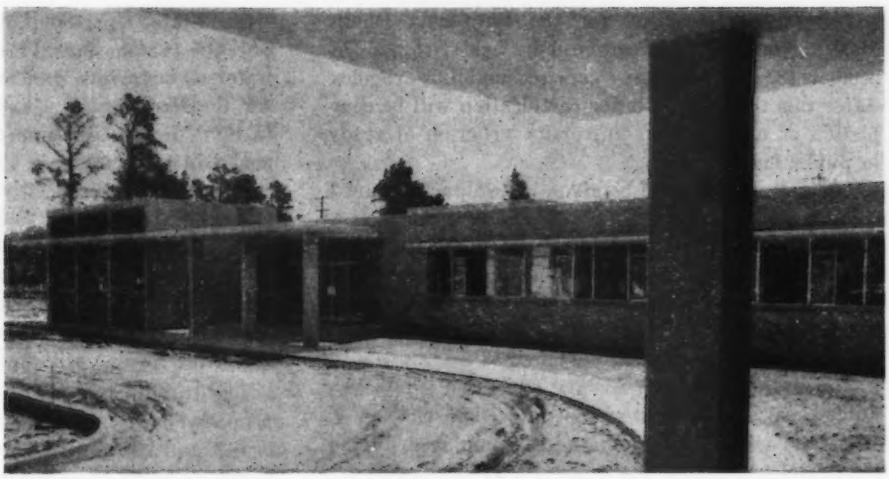
Part-time Jurisdictions

At this date vacancies exist in the part-time health officer positions in Trinity County, where the former health officer was Luther Selby, M.D., and in the city of San Joaquin in Fresno County, where the former health officer was A. C. Meracle, M.D.

Dr. Robert T. McMahon has succeeded Dr. Victor Stallone, Jr., as part-time health officer of the city of Albany, Alameda County.

Dr. Charles R. Milford has replaced Dr. Donald E. Thompson as part-time health officer of Tehama County.

SANTA CLARA COUNTY HEALTH CENTER



The Santa Clara County Health Department moved into its new health center at 2220 Moorpark Avenue, San Jose, early in May. The health center was built under the Hospital Survey and Construction Program with assistance from state and federal funds. The new building has a total of 20,555 square feet of floor space and was built at a cost of $480,476.—*Photo Courtesy Palo Alto Times.*

Local Public Health Services Bill Passed by State Legislature

Enactment of enabling legislation by the 1953 legislature may facilitate development of public health services in those areas of the State now without those services on a full-time organized basis. Sixteen California counties with sparse population are without full-time health departments because those counties have felt it to be too difficult from the financial standpoint to establish them under the previously existing provisions of the Health and Safety Code. This presented a real problem, for although these counties have only about 3 percent of the State's population they contain some of the most popular scenic and recreation areas into which tremendous numbers of visitors flock for both summer and winter sports.

Under the State Public Health Assistance Act of 1947, which added Chapter 8 to the Health and Safety Code, state funds were made available to the governing bodies of cities and counties to augment and improve public health services. These funds are not available unless a full-time health department is maintained that meets definite standards. Since none of these 16 counties could qualify for the assistance funds available to them (amounting to about $172,000 a year) these funds were unused.

With the addition to the Health and Safety Code of the new Section 1157, boards of supervisors are to enter into a contractual agreement with the State Department of Public Health for the introduction of organized public health services. Provision is now made for the allocation for this purpose of the public health assistance funds for which these counties had previously been ineligible, and a minimum necessary contribution of local funds is established.

Acceptance of such a plan is optional on the part of the county, and the extent of services to be rendered would be agreed upon by the board of supervisors and the State Health Department.

A health administrator might supervise work in more than one county, but each county could have its own staff.

Charles W. Arthur, Pasadena Health Officer, Retires

Charles W. Arthur retired May 1st from the health officership of Pasadena because of illness. He has given the Pasadena Health Department 32 years of outstanding service, since he went there in 1920 as city bacteriologist and director of laboratories. Prior to that appointment Mr. Arthur had been an instructor in the department of preventive medicine at the University of Missouri. He was promoted to associate health officer in 1929, and in 1941, was given the responsibility of the administration of the department at the time of the resignation of Dr. Wilton L. Halverson, now State Director of Public Health.

Mr. Arthur J. Holmes is now serving as acting health officer until June 16th when Wilber J. Menke, Jr., M.D., Dr.P.H., will become health officer. Dr. Menke is leaving the Bureau of Adult Health, State Department of Public Health, where he has been Medical Officer since November, 1952. Before that Dr. Menke was with the Division of Medical and Health Services, Office of Civil Defense.

Last Exam for State PHN Certificate to Be Held in December

The last examination for the California Public Health Nursing Certificate will be held Friday, December 18, 1953, in San Francisco and Los Angeles. After this the only basis for certification will be completion of an approved university program of study in public health nursing.

The examination will be given in two parts: Part I —9 a.m. to 12 noon; Part II—1 p.m. to 4 p.m.

All educational requirements must be completed before an applicant may be admitted to the examination for the certificate. This announcement is being made early enough to permit nurses needing additional courses to attend summer sessions.

Nurses employed by boards of education who began public health nursing work not later than October 1, 1951, and who remain continuously employed during the school years until December 18, 1953, may be admitted to the examination, provided all other requirements are met.

Nurses employed by health departments, visiting nurse services and other agencies where employment is for the full calendar year, who began public health work not later than January 2, 1952, and who remain continuously employed until December 18, 1953, may be admitted to the examination provided all other requirements are met.

Application forms and information in regard to requirements for admission to the examination may be obtained from the Bureau of Public Health Nursing, State Department of Public Health, Room 751, 760 Market Street, San Francisco 2.

Applications for admission to the examination should be in the Office of the Bureau of Public Health Nursing not later than November 20, 1953.

Mental Illness in California

The State Department of Mental Hygiene has produced a pamphlet entitled *Mental Illness in California.* It gives a clear and interesting description of the department's program to provide care and modern treatment for the mentally ill, the mentally deficient, certain types of deviated persons, and people with milder emotional disorders.

Fifty thousand patients are under the care or supervision of the Department of Mental Hygiene and $127,000,000 has been appropriated for the postwar building program to eliminate obsolete buildings and to relieve overcrowding.

Copies may be obtained by writing to the California State Department of Mental Hygiene, 1320 K Street, Sacramento.

Radiological Health Training Courses to Be Given June 15-July 31

The State Department of Public Health, on the basis of requests from several local health departments, from water departments, and other agencies, has arranged for the Radiological Health Training Branch of the U. S. P. H. S. Environmental Health Center, Cincinnati, Ohio, to conduct in California radiological health training courses especially designed for public health and related personnel. These courses are being offered from June 15th through July 31st. To permit a maximum number of people to attend three short courses of three to four days each will be given in the San Francisco Bay area and two short courses plus a two-week intensified course will be conducted in Los Angeles.

The training program is designed for professional people who are, or may be, concerned with radiological health and safety problems in their respective fields. While primary emphasis will be placed on the public health aspects of civilian uses of radioactivity, the applicability of the information to emergencies, including civil defense, will be presented. Candidates should have a technical background in public health, medicine, engineering, sanitation, nursing, physical science, or biological science.

All local health departments or other agencies desiring to have staff attend any of the sessions, should make necessary arrangements at once. No tuition will be charged. For further information and application forms write immediately to Arve H. Dahl, Radiological Health Survey Supervisor, Bureau of Adult Health, California State Department of Public Health, 2002 Acton Street, Berkeley 2, California.

Audiometry Courses Offered This Summer

To meet the demands of those who desire to enroll in a course in audiometry which would meet the certification requirements for school audiometrists, the following colleges have announced courses for the summer session 1953:

University of California, Santa Barbara College	6 weeks—3 units
San Francisco State College	6 weeks—3 units
Whittier College	6 weeks—2 units
Los Angeles State College	6 weeks—6 units

(This institution requires the course, Introductions to Audiology, as a prerequisite or taken simultaneously.)

Although not yet announced, an approved course may be offered this summer at San Jose State College.

For further information inquiry should be made to the Dean of Summer Session at any of the colleges listed above.

Local Public Health Laboratory Directors Attend Institute

The Fourth Annual Institute for Local Public Health Laboratory Directors presented by the Division of laboratories of the State Department of Public Health was held at Asilomar, May 8th through 10th. Those attending included representatives from 39 of the State's 43 public health laboratories; members of the State Health Department staff from the Bureau of Veneral Diseases, Bureau of Acute Communicable Diseases, Division of Local Health Service, and Division of Laboratories; representatives from the U. C. School of Public Health and the U. C. L. A. Department of Bacteriology.

Among the topics discussed was the venereal disease research laboratory test for syphilis. This test has been subjected to sufficient experimental testing to prove its value as a routine procedure institute attendants were told. It was recommended by the Division of Laboratories for use in the local laboratories because of the greater reproductibility of the cardiolipin antigen employed and because of the greater specificity, especially in such cases as malaria.

Dr. Ralph Hogan, Medical Director, Chief of the Branch Laboratory, Communicable Disease Center, Atlanta, Georgia, reviewed activities of the laboratory branch of C. D. C. as related to state and local laboratories. The C. D. C. laboratory branch provides consultive service to state laboratories in the fields of virology, bacteriology, parasitology, mycology, hematology and biochemistry. To secure assistance from this laboratory, specimen material must be submitted to the State Health Department for reference to the Communicable Disease Center. The C. D. C. laboratory branch also offers various types of training programs in the above fields of laboratory endeavor. Such training programs may include visits from the staff to the states whenever requested.

Problems relating to sanitary bacteriology and chemistry were discussed by staff of the sanitation laboratory and the Los Angeles branch laboratory of the Division of Laboratories. Included was a review of the findings of the sanitation laboratory on studies of the molecular filter membranes. These studies are part of a nation-wide comparison of the filter technic with the standard technics for the determination of the bacteriologic quality of water. The opinion was expressed that this technic has not been developed to the point where it can replace the current standard technics.

Individual presentations were made of local health department investigations in outbreaks of diphtheria, typhoid fever, encephalitis and diarrheal diseases. The panel members presenting these topics emphasized the following:

1. Culturing all diphtheria contacts may not be feasible; the health officer may decide that immunization of susceptible persons may be a better procedure.
2. Anal swabs for the detection of Salmonellae, typhosa, are not satisfactory except for authenticating specimens.
3. Diarrheal studies indicate that although certain technics can be streamlined, it is essential to make multiple pickings of every type of colony that is not a frank coliform.
4. All isolations of enteric pathogene should be submitted to the Division of Laboratories, including those isolations obtained from previously diagnosed cases.
5. The Widal reaction must be evaluated carefully in view of the possible suppression of antibiotics, the false positives occurring in infectious mononucleosis, and the prevalence of positive agglutinations in young men from the armed forces.

One of the highlights of the meeting was a presentation of a paper by Dr. Robertson Pratt of the College of Pharmacy, University of California, on "The Effect of Certain Antibiotics on Cultural and Morphologic Characteristics of Micro-organisms."

A panel was presented on the "Contribution of the Public Health Laboratory to the Health Department and to the Community." Participants in this panel were Seiko Baba, Dr. John Philp, Dr. James C. Malcolm, Dr. M. H. Merrill and Nancy Davis. This panel was a prologue to group discussions held later in the institute. The panel discussion centered around the internal relationships within the laboratory, the relationships of the laboratory to the health department staff and to the community, including personnel working in private and hospital laboratories, and some of the possible future trends of public health laboratory services.

It was indicated that certain aspects of the laboratory tests for viral and rickettsial diseases have developed to the point where local laboratories may now look forward to the performance of these tests. A plan was presented for the training of personnel and establishment of these tests in local laboratories interested in their performance. A brief review was given of the status of laboratory tests in the examination of specimens for poliomyelitis. It was indicated that by means of tissue culture technic isolations and identification of type can now be accomplished with more rapidity and less expense than heretofore.

Use of Placentas for Gamma Globulin Urged by State Board

In an effort to make more immune serum globulin available to the public, the California State Board of Public Health has passed a resolution asking hospitals to supply human placentas to firms which are licensed to produce biologics. The resolution follows:

WHEREAS, Immune serum globulin has been demonstrated to be an effective adjunct in decreasing morbidity and mortality in certain communicable diseases, particularly measles, and has been indicated to be of value in the prophylaxis of poliomyelitis; and

WHEREAS, The availability of this biologic to the public will be in short supply; and

WHEREAS, It is in the interest of the public health that there be made available a continuing supply of this product; and

WHEREAS, The only source of such immune serum globulin is human blood; and

WHEREAS, It has been shown that the blood contained in human placentas serves as a most valuable and dependable source of human blood serum from which immune serum globulin may be prepared; and

WHEREAS, Such placentas are currently being discarded when products derived therefrom may be utilized in the prevention of illness and death of children; now, therefore, be it

Resolved, That the State Board of Public Health recommend and urge that hospitals in California, whenever practicable, make the above materials available to regularly licensed biologic producing houses for the processing of immune serum globulin in order that this important product be available to the public; and be it further

Resolved, That a copy of this resolution be provided such hospitals and licensed biologic producing houses.

The ideal of community health organization is nothing less than the mobilization of all the rich and varied forces within an American community in free and friendly association to combat a common enemy and to strive for the common heritage of health and longevity.—*Leonard A. Scheele, M.D., Surgeon General, U. S. P. H. S.*

Review of Reported Communicable Disease Morbidity—April, 1953

Diseases With Incidence Exceeding the Five-year Median

Diseases	*April 1953*	*April 1952*	*April 1951*	*5-year median*
Amebiasis	44	34	43	34
Coccidioidomycosis	10	7	8	7
Encephalitis, infectious	6	5	4	4
German measles	3,172	2,580	755	755
Hepatitis, infectious	114	48	17	34
Influenza	213	484	452	135
Malaria	6	2	1	1
Meningitis, meningococcic	49	53	18	22
Mumps	5,141	4,471	1,997	4,662
Poliomyelitis	87	49	51	45
Salmonella infections	67	64	22	22
Shigella infections	98	60	29	24
Streptococcal infections, respiratory, including scarlet fever	903	1,009	866	520

Diseases Below the Five-year Median

Diseases	*April 1953*	*April 1952*	*April 1951*	*5-year median*
Brucellosis	8	11	11	11
Chickenpox	6,398	9,647	5,401	7,054
Diphtheria	3	14	11	31
Food poisoning	26	173	37	38
Measles	9,607	10,885	15,151	10,885
Pertussis	294	443	190	418
Rabies, animal	17	24	4	20
Typhoid fever	3	7	3	6

Venereal Diseases

Diseases	*April 1953*	*April 1952*	*April 1951*	*5-year median*
Syphilis	611	768	733	899
Gonococcal infections	1,540	1,460	1,191	1,503
Chancroid	19	28	18	[1]
Granuloma inguinale	—	—	—	—
Lymphogranuloma venereum	6	9	1	[1]

[1] Median not calculated.

Accidents in our Country claim about 6,000 lives annually among children at ages 5 to 14 years. This is nearly twice the total of young lives taken by leukemia and other cancers, acute poliomyelitis, and pneumonia and influenza. Accidents now account for fully one-third of all deaths at the elementary school ages, whereas about 15 years ago the proportion was only one-fifth. This relative increase reflects the more rapid gains achieved in the conquest of disease than in the control of accidents. While the rate from fatal injuries at the school ages fell 30 percent between 1933-1934 and 1948-1949, the mortality from disease dropped 65 percent. Now more than ever before, accidents constitute the greatest threat to the life of American youngsters.—*Statistical Bulletin, Metropolitan Life Insurance Company*, Vol. 33, No. 9.

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